STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155148	B. WING		02/07/2013
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
NORTH I	PARK NURSING C	CENTER		AIRWAY DR SVILLE, IN 47710	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG F0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for	the Investigation of	F0000		
	Complaint #IN00	_	10000		
		.2000 1.			
	This visit was in o	conjunction with the			
		d State Licensure Survey			
	completed on 02/	•			
	F				
	Complaint #IN00	123081: Substantiated.			
	Federal/State deficiencies related to the				
		ted at F282 and F315.			
	Survey dates: January 28, 29, 30, 31, and				
	February 1, 5, 6, 7, 2013				
	_				
	Facility number:	000069			
	Provider number:	155148			
	AIM number: 100	288980			
	Survey team:				
	Amy Wininger, RI	N TC			
	Barb Fowler, RN				
	Diane Hancock, F	RN			
	Census bed type:				
	SNF:	12			
	SNF/NF:	84			
	Total:	96			
	Concue navor tun	no.			
	Census payor typ Medicare:	22			
	Medicaid:	67			
	Other:	7			
	Olliei.	1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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TITLE

000069

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		A. BUILDING B. WING	00	— 02/07	LETED 7/2013	
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			650 FAI	ADDRESS, CITY, STATE, ZIP C RWAY DR VILLE, IN 47710	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 96	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Sample:	3 s also reflect state findings				
	in accordance with					
	by Jodi Meyer, RN	preced on 1 cordary 14, 2013,				

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Event ID: RL9B11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building			COMPLETED	
		155148	B. WIN			02/07/	2013
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				IRWAY DR		
NORTH PARK NURSING CENTER					VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services proving facility must be propersons in accord written plan of car Based on interview, the faci resident with an catheter receive the care plan, in reviewed for haurinary catheter 3, did not have according to the (Resident #B) Findings included The clinical receives according to the (Resident #B) Findings included The clinical receives reviewed to p.m. The Physician adated 08/09/12 limited to, the finding included 10 to the	view, and record lity failed to ensure a n indwelling urinary ed care according to n that, 1 of 1 residents aving an indwelling r, in a total sample of the catheter changed e plan of care. e: ord of Resident #B on 01/30/13 at 1:58 Admission Orders included, but was not following order ndwelling urinary ery] month et [and] prn	F02	82	F282 Services by qualified person/ per care plan 1.Resident B discharged from facility on 1/17/13. 1.All residents requiring the confine of indwelling urinary catheter have the potential to be affected by the alleged deficient practice. An audit was completed of the identified resident's records to ensure that catheters had been changed and/or were schedule to be changed in accordance to current physician order and plate of care. Nurses in serviced on 2/26/13 per SDC related to changing of catheters in accordance to physicians order. 3. Nurses in serviced on 2/26/19 per SDC related to changing of catheters in accordance to physicians orders. Catheters where the maintained and changed per physicians' orders by DNS/designee monitoring the TAR. DNS/designee will monit by reviewing physician orders ensure catheters are changed order. DNS/Designee will ensure catheter care will be included if the residents' comprehensive plan of care.	use ed eed oo an ers. 13 f will er or to per ure	03/09/2013

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Event ID: RL9B11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMP			COMPL	ETED
		155148	B. WIN			02/07/	2013
			D. 1711		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	£		650 FAI	RWAY DR		
NORTH PARK NURSING CENTER				EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	documentation changed betwee 09/19/12. The handwritten no 09/19/12" and [an indwelling to 09/28/12 then Nov. 9, 2012." 2012 had been an undated, ha indicated, "Oct frame between equaled 6 wee A physician tel 09/19/12 indicationchange Foleweeks"	tes "changed on "Change Foley cath urinary catheter] on q 6 weeks. due again The date of Nov 9, n crossed through and andwritten note above 31st 2012." (The time			4. DNS /designee will complete catheter monitoring tool 5x we for 2 weeks, 3x week for 2 week 2x week for 2 weeks, then week x 6 weeks and monthly for 3 months to ensure that catheter are changed according to physicians order. Failure to comply with guidelines will resin disciplinary action up to and including termination. Results catheter monitoring tool will be monitored in QA for a minimur 6 months, if a threshold of 95% not met an action plan will be developed. 5. Completion Date: May 9 th, 2013	ek eks, ekly rs ult of e n of 6 is	
	and as needed included a han indicated, "cha nov. 9" The TA	l occlusion." The entry dwritten note that nged 09/19/12 and due AR lacked any					
	changed during	the catheter had been g October 2012.					
	but was not lim "Change Foley	2012 TAR included, nited to, an order for catheter every month l occlusion." The TAR					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	D PLAN OF CO	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			155148	B. WIN			02/07/	2013
MAINE OF TROVIDER OR SUFFLIER	ME OF PROVII	VIDER OR SUPPLIER	₹					
NORTH PARK NURSING CENTER 650 FAIRWAY DR EVANSVILLE, IN 47710	NORTH PARK NURSING CENTER							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (X5)	4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
CROSS-REFERENCED TO THE APPROPRIATE		*				CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE			· · · · · · · · · · · · · · · · · · ·	_	TAG	DEFICIENCY)		DATE
indicated the catheter had been								
changed on November 9, 2012 (The		•	•					
time frame between catheter changes			_					
equaled 7 weeks and 2 days)	l edi	qualeu / wee	iks allu 2 uays)					
A Care Plan for indwelling catheter	A	Care Plan fo	or indwelling catheter					
dated 10/29/12 included, but was not			•					
limited to, an intervention of,			-					
"change catheter per MD order"								
During an interview on 02/05/13 at		•						
8:30 a.m. the DoN [Director of			=					
Nursing] indicated she could provide			•					
no documentation the catheter had	I							
been changed between 08/09/12 and		•						
09/19/12 or between 09/28/12 and								
11/09/12. She further indicated, at that time, it was standard practice for								
the facility to change the catheter			-					
according to the Physician's orders.		-	•					
decoraing to the range orders.		loooraing to th	ic i flyblolair b bracib.					
This Federal tag relates to complaint	Thi	his Federal ta	ag relates to complaint					
IN00123081.								
3.1-35(g)(2)	3.1	3.1-35(g)(2)						

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Event ID: RL9B11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED	
		155148	B. WING		02/07/2013
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	l .
NAME OF P	PROVIDER OR SUPPLIE	R	650 FA	AIRWAY DR	
NORTH I	PARK NURSING C	ENTER		SVILLE, IN 47710	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	A83.25(d) NO CATHETER, BLADDER Based on the resident who entindwelling cathet the resident's clin that catheterizati resident who is in receives approprion prevent urinar restore as much possible. Based on interreview, the factor review, the factor review, the factor resident with a catheter received to the Physicial residents reviewind welling urin sample of 3, dichanged accorder. (Resident Findings included the clinical receives reviewed p.m. The recompliance of the properties of the properties included the clinical receives a properties in the clinical receives a properties and the clinical receives a properties	PREVENT UTI, RESTORE sident's comprehensive facility must ensure that a ers the facility without an er is not catheterized unless nical condition demonstrates on was necessary; and a ncontinent of bladder iate treatment and services by tract infections and to normal bladder function as eview and record fility failed to ensure a an indwelling urinary by ed services according an's order, in that, 1 of 1 and the wed for having an ary catheter, in a and not have the catheter and not		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	I, 03/09/2013 I see ed ce. e. e
	dated 08/09/12	2 included, but was not following order		physicians' orders by DNS/designee monitoring the TAR. DNS/designee will monit	tor

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Event ID: RL9B11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A PLUI DING 00 COMPLE		COMPLETED
		155148	A. BUILDING B. WING		02/07/2013
			_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		AIRWAY DR	
NODTH I	PARK NURSING C	ENTED		SVILLE, IN 47710	
NORTH		ENTER	EVAIN	3VILLE, IN 477 10	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	"change f/c [indwelling urinary		by reviewing physician orders	l l
	catheter] q [ev	ery] month et [and] prn		ensure catheters are changed	-
	[as needed] od	cclusion"		order. DNS/Designee will enscatheter care will be included	
				the residents' comprehensive	
	The August 20	012 TAR [Treatment		plan of care.	
	_	Record] lacked any			
		the catheter had been		4. DNS /designee will comple	
		een 08/09/12 and		catheter monitoring tool 5x we	
	08/31/12.	cen 66/65/12 and		for 2 weeks, 3x week for 2 we	
	00/31/12.			2x week for 2 weeks, then we	ekly
	The Orante wells			x 6 weeks and monthly for 3 months to ensure that cathete	are
	The September 2012 TAR lacked any			are changed according to	13
		n the catheter had been		physicians order. Failure to	
	_	een 09/01/12 and		comply with guidelines will re-	sult
	09/19/12. The	e TAR included		in disciplinary action up to an	
	handwritten no	otes "changed on		including termination. Results	
	09/19/12" and	"Change Foley cath		catheter monitoring tool will b	
	[an indwelling	urinary catheter] on		monitored in QA for a minimu	
	_	q 6 weeks. due again		6 months, if a threshold of 95	% IS
		The date of Nov 9,		not met an action plan will be developed.	
		n crossed through and		developed.	
		andwritten note above		5. Completion Date: M	arch
	•			9 th , 2013	
		t 31st 2012." (The time			
		n catheter changes			
	equaled 6 wee	eks.)			
		lephone order dated			
	09/19/12 indic	ated an order for			
	"change Foley catheter every 6				
	weeks"				
	The October 2	012 TAR included, but			
		d to, an order for			
		catheter every month			
		-			
		d occlusion." The entry			
	included a har	ndwritten note that			

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE : COMPL 02/07/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR					
	PARK NURSING C			VILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
IAU	indicated, "chanov. 9" The Tradocumentation changed during. The November but was not lim "Change Foley and as needed indicated the changed on Notime frame betwequaled 7 wee. A Care Plan for dated 10/29/12 limited to, an ir "change cathodated 10/29/12 limited 10/29/12	nged 09/19/12 and due AR lacked any the catheter had been g October 2012. 2012 TAR included, nited to, an order for catheter every month l occlusion." The TAR atheter had been evember 9, 2012 (The ween catheter changes ks and 2 days) r indwelling catheter g included, but was not	IAG			DATE		
<u> </u>	I .		<u> </u>	I .		<u> </u>		

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Event ID: RL9B11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/07/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	l
				IRWAY DR	
	PARK NURSING CI			VILLE, IN 47710	•
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE

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